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SENATE BILL 290 By
Clabough

HOUSE BILL 845
By McCord

AN ACT to amend Tennessee Code Annotated, Title 56, Chapter 7, relative to providing access to health insurance coverage to certain individuals.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by adding the following language as new sections to be designated as follows:

56-7-2326. Sections 56-7-2326 — 56-7-2346 shall be known and may be cited as the "Comprehensive Health Insurance Pool Act".

56-7-2327. It is the purpose and intent of the general assembly to provide access to health insurance coverage to all residents of Tennessee who are denied adequate health insurance for any reason from any insurer. It is the intent of the general assembly that adequate levels of health insurance coverage be made available to residents of Tennessee who are otherwise considered uninsurable or who are underinsured. It is the intent of §§ 56-7-2326 — 56-7-2346 to provide a mechanism that assists persons who are unable to directly obtain health insurance coverage on an individual or group basis under any plan to obtain comprehensive health insurance.

56-7-2328. As used in §§ 56-7-2326 — 56-7-2346, unless the context otherwise requires:

(1) "Board" means the board of directors of the pool;

(2) "Commissioner" means the commissioner of finance and administration;

(3) "Health care institution" means any facility, institution, agency or place providing health care services;

(4) "Health care provider" means any physician, institution or a health care professional, who is licensed in Tennessee and entitled to reimbursement for health care services under this title;

(5) "Health care services" means any services or products included in the furnishing to any individual of medical care or hospitalization, or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing or healing human illness or injury;

(6) "Health insurance" means any hospital and medical expense incurred policy, nonprofit health care service plan contract and health maintenance organization subscriber contracts. "Health insurance" does not include short-term, accident, fixed indemnity, long-term care insurance, disability income contracts, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of the workers' compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

(7) "Health maintenance organization" or "HMO" means an organization as defined in § 56-32-202;

(8) "Health plan" means any arrangement by which persons, including dependents or spouses, covered or making application to be covered under this pool, have access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contracts; coverage through health maintenance organizations, preferred provider organizations or other alternate delivery systems; coverage under prepayment, group practice or individual practice plans; coverage under uninsured arrangements of group or group-type contracts including employer self-insured, cost-plus or other benefit methodologies not involving insurance or not subject to Tennessee premium taxes; coverage under group-type contracts which are not available to the general public and can be obtained only because of connection with a particular organization or group; and coverage by Medicare or other governmental benefits. "Health plan" includes coverage through "health insurance," as defined under this section, and specifically excludes those types of programs excluded under the definition of "health insurance" in this section;

(9) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer or other health care plan;

(10) "Insurer" means any insurance company authorized to transact accident and sickness insurance business in this state, any hospital and medical service corporation and any health maintenance organization;

(11) "Medicare" means coverage under both Parts A and B of Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq., as amended;

(12) "Plan of operation" means the pool, including articles, bylaws and operating rules, adopted by the board pursuant to § 56-7-2330;

(13) "Pool" means the Tennessee comprehensive health insurance pool as created in § 56-7-2329;

(14) "Preferred provider organization" means any person, partnership, association, corporation or entity which contracts with a hospital, hospitals and/or other health care providers for the provision of health care services by the hospital, hospitals and/or health care providers at a discounted rate, a per diem charge or any other pricing arrangement which is less than the charge made for medical services without such a contract arrangement; and

(15) "Resident of this state" means continuous physical presence and maintenance of a dwelling place within this state; provided, that absence from the state for short periods of time shall not affect the establishment of a residence.

56-7-2329.

(a) There is hereby created a nonprofit entity to be known as the Tennessee comprehensive health insurance pool. All insurers issuing health insurance in this state and providing health plan benefits in this state on and after July 1, 2003, shall be members of the pool. Any person, partnership, association, corporation or entity operating a health maintenance organization in the state on or after July 1, 2003, shall also be members of the pool.

(b) The commissioner shall, within ninety (90) days after July 1, 2003, give notice to all insurers of the time and place for the initial organizational meetings of the pool. The commissioner shall select the eleven (11) member board of directors. The board shall at all times, to the extent possible, include at least one (1) representative of a domestic insurance company licensed to transact health insurance, one (1) representative of a foreign insurance company, one (1) representative of a domestic nonprofit health care service plan, one (1) representative of a health maintenance organization, one (1) doctor of medicine, one (1) hospital administrator, one (1) person covered by the Tennessee comprehensive health insurance pool, one (1) member from the general public who is not associated with the medical profession, a hospital or an insurer, and one (1) member

to represent a group considered to be "uninsurable." In making appointments to the comprehensive health insurance pool board of directors, the commissioner shall strive to ensure that at least one (1) person serving on the board is sixty (60) years of age or older and that at least one (1) person serving on the board is a member of a racial minority.

(c) The original board of directors shall be appointed for the following terms: three (3) members for a term of one (1) year, three (3) members for a term of two (2) years, and three (3) members for a term of three (3) years. Thereafter, all board members shall be appointed by the commissioner for a term of three (3) years. Board members shall receive no compensation but shall be reimbursed for all travel expenses in accordance with the travel regulations promulgated by the department of finance and administration and approved by the attorney general and reporter.

(d) The board, on an annual basis, shall submit to the commissioner and the comptroller of the treasury a funding plan and a plan for operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool and its financial solvency based upon timely and accurate actuarial assumptions. The commissioner and the comptroller of the treasury shall approve the funding plan and the plan of operation if they determine that the plans assure the financial solvency of the pool, the fair, reasonable and equitable administration of the pool, provide for the sharing of pool losses on an equitable, proportionate basis among the members of the pool and otherwise are in compliance with the provisions of this chapter.

(e) Board members are state officials and as such are absolutely immune from liability for acts or omissions within the scope of their duties as board members, except for willful, malicious or criminal acts, or omissions done for personal gain.

56-7-2330. The plan of operation submitted by the board to the commissioner shall:

(1) Establish procedures for the handling and accounting of the assets and moneys of the pool;

(2) Establish regular times and places for a meeting of the board of directors;

(3) Establish procedures for records to be kept of all financial transactions and for an annual fiscal reporting to the commissioner;

(4) Contain additional provisions necessary and proper for the execution of the powers and duties of the pool;

(5) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made;

(6) Establish the amount of assessment pursuant to § 56-7-2331, which shall occur annually at the end of each calendar year, and which shall be due and payable within thirty (30) days of the receipt of the assessment notice;

(7) Select an administrator in accordance with § 56-7-2336; and

(8) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.

56-7-2331. The board has the general powers and authority granted under the laws of this state to insurance companies licensed to transact the kinds of insurance defined under § 56-2-201. In addition thereto, the board has the specific authority to:

(1) Enter into contracts as are necessary or proper to carry out the provisions and purposes of §§ 56-7-2326 — 56-7-2346 including the authority,

with the approval of the commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(2) Sue or to be sued, including taking any legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool. For the purposes of this provision, as well as for legal representation of the Tennessee comprehensive health insurance pool, the Tennessee comprehensive health insurance pool is considered to be an instrumentality of the state for the purposes of being represented by the attorney general and reporter, pursuant to § 8-6-109;

(3) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agent referral fees, claim reserve formulas and any other actuarial functions appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim costs and shall take into consideration appropriate risk factors in accordance with established actuarial underwriting practices;

(4) Assess members of the pool in accordance with the provisions of this chapter and to make advance interim assessments as may be reasonable and necessary for the organizational or interim operating expenses. Any such interim expenses will be credited as offsets against any regular assessments due following the close of the calendar year;

(5) Issue policies of insurance in accordance with the requirements of this chapter;

(6) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool;

(7) Request an annual audit by the comptroller of the treasury as otherwise provided by law or, with the prior written approval of the comptroller of the treasury, contract with an independent public accountant for the audit; and

(8) Determine the eligibility requirements for plan participants and their dependents in accordance with the provisions of §§ 56-7-2326 — 56-7-2346.

56-7-2332. The board of directors shall submit, not later than October 1 of each year, a financial report for the preceding fiscal year in a form approved by the commissioner. The board of directors shall further report to the appropriate standing committees of each house by April 1 of each year.

56-7-2333. The pool shall not provide coverage to any individual who, on the effective date of the coverage applied for, already has or would have coverage substantially equivalent to pool coverage as an insured or covered dependent or who would be eligible for such coverage if such individual elected to obtain it.

56-7-2334. (a)

(1) The pool shall be funded in the manner set forth in this section.

(2) The pool shall collect premiums from plan participants in accordance with this section and § 56-7-2342.

(b) Following the close of each fiscal year, the commissioner shall prepare a report analyzing the pool's projected revenues and expenditures and funding requirements. The commissioner shall present this report, together with the board's comments, to the general assembly and the governor with a recommendation for the funding of the pool.

(c)

(1) Should the pool's claims payments and other expenses exceed the premiums collected and the state appropriation, the pool members shall be assessed by the board for the amount of the shortfall.

(2) The total amount of the assessments authorized under this subsection shall at no time exceed the amount appropriated by the state to the pool.

(3) Each pool member's proportion of the shortfall shall be equal to that member's proportion of its premium and subscriber contract charges for health insurance written in the state during the preceding calendar year as compared to the total of all premiums and subscriber contract charges written in the state. Each member's proportion of the shortfall shall be determined by the board based upon annual statements filed with the department of commerce and insurance, or such other reports or information deemed necessary by the board.

(d) The commissioner of commerce and insurance, with the approval of the commissioner of finance and administration, may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the commissioners of commerce and insurance and finance and administration, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (c). The member receiving such abatement or deferment shall remain liable to the pool for deficiency for four (4) years.

(e) It is unlawful for any member to fail or refuse to pay an assessment or to respond to an inquiry from the pool or the commissioner regarding information necessary to make assessments within forty-five (45) days of the assessment notice or request for information.

(f) Whenever the commissioner has reason to believe that a member has failed or refused to pay an assessment, or has failed or refused to respond to a request for information necessary to make assessments in a timely fashion or has failed or refused to register in accordance with the provisions of §§ 56-7-2326 — 56-7-2346, the commissioner may issue and serve upon such a member a notice of hearing to determine whether the member has failed or refused to pay an assessment or respond to an inquiry or register in a timely fashion. Such hearing shall be conducted in accordance with the Uniform Administrative Procedures Act, compiled in Title 4, Chapter 5.

(g) If, after notice and hearing, the commissioner determines that the member has failed or refused to pay an assessment, or has failed or refused to provide information necessary to make assessments in accordance with §§ 56-7-2326 — 56-7-2346, or has failed or refused to register in accordance with the provisions of §§ 56-7-2326 — 56-7-2346, the commissioner may assess a civil penalty of not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000) for each and every act or violation. Each day in which the member has failed or refused to pay an assessment or to provide information necessary to make assessments or register in accordance with §§ 56-7-2326 — 56-7-2346 constitutes a separate act or violation. The commissioner may, if the commissioner determines that the member knew or reasonably should have known that such member was in violation of §§ 56-7-2326 — 56-7-2346, suspend or revoke the member's certificate of authority to transact insurance business in this state.

56-7-2335.

(a) Any individual person, including the individual's eligible dependents as defined by the board, who has been a resident of this state for one (1) year shall be eligible for coverage, except the following:

(1) Persons who have or who are eligible to have on the day of issue of coverage by the pool substantially equivalent coverage under health insurance or other health plan;

(2) Any person who is at the time of pool application eligible for health care benefits under Title 71, Chapter 5;

(3) Any person having terminated coverage in the pool, unless twelve (12) months have lapsed since such termination;

(4) Any person on whose behalf the pool has paid out one million dollars ($1,000,000) in benefits; or

(5) Inmates of public institutions and persons whose benefits are duplicated under public programs.

(b) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium, and who is not eligible for conversion, or who is not covered by substantially equivalent health plans, may apply for coverage under the plan. If such coverage is applied for within sixty (60) days after the involuntary termination, and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

(c) It is unlawful for any employer or insurer to entice or coerce any individual to participate in the pool who is otherwise eligible to participate in a group comprehensive health insurance plan for the purpose of reducing the group plan premiums or self-insurance costs. Any denial of coverage must be based upon preestablished policies and conditions that are mandated for the entire group and its participants. The board has the authority and responsibility to adopt policies and procedures that effectively implement this provision. Such policies and procedures shall be included in its plan of operation. The pool is authorized to enter into agreements with employer-sponsored health plans for employer-sponsored participation of its employees who are denied

coverage based upon the preestablished policies and conditions required by this subsection.

(d) Each pool member's proportion of eligible persons to whom insurance coverage must be provided by such pool member shall be equal to that member's proportion of the revenues generated pursuant to § 56-32-224 or the tax on gross premiums pursuant to § 56-4-205 during the preceding calendar year as compared to the total of all taxes generated pursuant to such sections. Each member's proportion of persons eligible for coverage shall be determined by the board based upon annual statements filed with the department of commerce and insurance, or such other reports or information deemed necessary by the board.

56-7-2336.

(a) The board shall provide for administration of the pool by electing in its plan of operation to have the pool administered:

(1) By the commissioner through the state group insurance office;

(2) By selecting an administrator through a competitive proposal process; or

(3) Through a combination of both.

(b) If the board should elect to procure the services of an administrator, the board shall evaluate the proposals on criteria established by the board which shall include:

(1) The administrator's proven ability to handle accident and health insurance;

(2) The efficiency of the administrator's claim paying procedures;

(3) An estimate of total charges for administering the plan; and

(4) The administrator's ability to administer the pool in a cost-efficient manner.

(c)

(1) The administrator may provide for all eligibility and administrative claim payment functions relating to the pool.

(2) The administrator shall establish a premium billing procedure for collection of premiums from insured persons. Billings shall be made on a periodic basis as determined by the board, which shall not be more frequent than a monthly billing.

(3) The administrator shall provide for all necessary functions to assure timely payment of benefits to covered persons under the pool including:

(A) Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made; and

(B) Evaluating the eligibility of each claim for payment by the pool.

(4) The administrator shall submit regular reports to the board regarding the operation of the pool. The frequency, content and form of the report shall be as determined by the board.

(5) Following the close of each fiscal year, the administrator shall determine net written and earned premiums, the expense of administration and the paid and incurred losses for the year, and report this information to the board and the commissioner on a form as prescribed by the commissioner.

(6) All administrative costs of the pool shall be paid from the pool fund.

56-7-2337.

(a)

(1) The board shall be responsible for establishing all benefit levels associated with the operations of the pool.

(2) The health insurance policy issued by the pool shall pay only usual and customary charges for medically necessary eligible health care services rendered or furnished for the diagnosis or treatment of illness or injury which exceeds the deductible and co-insurance amounts as established by the board and which are not otherwise limited or excluded.

(3) Eligible expenses are the charges for the health care services and items for which benefits are extended under the pool policy.

(4) Once the board establishes the pool benefits and exclusions, it shall prepare a brochure outlining the benefits and exclusions of the pool benefit policy in an easy-to-read language and which shall be made reasonably available to participants or potential participants.

(b)

(1) The board has the authority to specify limitations and exclusions, specifically including exclusions for preexisting conditions, in addition to the minimum benefits required under subsection (a).

(2) Such exclusions and benefits shall be generally reflective and commensurate with those contained in health plans provided through a representative number of large employers across the state.

(3) The board has the authority to establish deductibles, co-insurance and maximum out-of-pocket payments for eligible expenses.

(c) Sections 56-7-2326 — 56-7-2346 do not prohibit the pool from issuing additional types of health insurance policies with different types of benefits, which, in the opinion of the board of directors, may be of benefit to those individuals otherwise eligible for coverage.

(d) The board of directors may, at its discretion, design and employ managed care methods and cost containment measures and requirements such as, but not limited

to, pre-admissions certification, concurrent inpatient review and preferred provider organizations which may make the pool more cost-effective.

56-7-2338.

(a) The board shall establish a qualified Medicare supplemental health coverage for eligible persons who are enrolled under Title 1, Part 1 of Public Law 89-97 and amendments thereto (Health Insurance for the Aged Act), known as Medicare. The plan of health care coverage must meet the minimum standard requirements for Medicare supplemental coverage as specified under Chapter 7, Part 14 of this title and the Rules and Regulations of the department of commerce and insurance. No benefits may be provided for expenses that are not Medicare eligible expenses, except for prescription drugs. The board shall establish the scope of benefits for prescription drugs.

(b) The board shall establish rates for the Medicare supplemental plan that are reasonable in relation to:

(1) The benefits provided; and

(2) The risk associated with persons eligible for the plan.

56-7-2339.

(a) A pool policy offered under §§ 56-7-2326 — 56-7-2346 must contain provisions under which the pool is obligated to renew the contract until the day on which the individual in whose name the contract is issued first becomes eligible for Medicare coverage, except that in a family policy covering both spouses, the age of the younger spouse must be used as the basis for meeting the durational requirement of this subsection.

(b) The pool may not change the rates for pool policies except on a class basis with a clear disclosure in the policy of the pool's right to do so.

(c) Pool coverage under §§ 56-7-2326 — 56-7-2346 must provide that upon the death of an individual who is covered by the pool and who has dependents also covered

by the pool as a result of the individual's coverage, the dependents may elect, within a period as established by the board, to continue coverage until such time as the deceased would have ceased to be entitled to coverage had the individual in whose name the coverage was issued lived.

56-7-2340. The commissioner shall adopt rules that:

(1) Provide for disclosure by carrier of the availability of insurance coverage from the pool; and

(2) Implement §§ 56-7-2326 — 56-7-2346.

56-7-2341. Neither the participation by insurers in the pool, the establishment of rates, forms, or procedures for coverages issued by the pool, nor any other joint or collective action required by §§ 56-7-2326 — 56-7-2346 shall be the basis of any legal action, civil or criminal liability or penalty against the pool members of it either jointly or separately.

56-7-2342.

(a) Premiums charged for coverage may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses provided in the coverage. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks.

(b) The pool shall determine the standard risk rate by using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Except as provided in § 56-7-2338, maximum rates for pool coverage shall be one hundred fifty percent (150%) of the rates established as applicable for individual standard risks. In the event that the combined amounts of premium collections, the appropriation contained in the General Appropriations Act and the assessment from the pool members do not result in an actuarial sound fund balance, the board will then have the authority to raise the premium to an amount in excess of the maximum, in order to

place the pool in a fiscally sound condition. All rate schedules shall be submitted to the commissioner and the comptroller of the treasury for their approval.

56-7-2343. It is the express intent of §§ 56-7-2326 — 56-7-2346 that the pool be the last payor of benefits whenever any other benefit is available. Coverage under any pool policy is in excess of, and may not duplicate, coverage under any other form of health insurance.

(1) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance or health benefit plans, including, but not limited to, self-insured plans and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(2) The administrator of the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any amount recoverable under this subdivision.

56-7-2344. The pool and the premium collected by the pool shall be exempt from the premium tax, the gross income tax, the adjusted gross income tax, supplemental corporate and income, or any combination of them or similar taxes on revenues or income that may be imposed by Tennessee.

56-7-2345.

(a) The comprehensive health insurance pool fund shall be established as a separate account in the state treasury.

(b) Moneys in the comprehensive health insurance pool fund, including interest earned on such moneys, shall be invested by the state treasurer pursuant to §§ 9-4-602 and 9-4-603 for the sole benefit of that fund.

(c) Any moneys remaining in the comprehensive health insurance pool fund at the end of the fiscal year shall not revert to the general fund, but shall be brought forward to the next fiscal year for the exclusive benefit of the comprehensive health insurance pool fund.

56-7-2346. Whenever the board determines that the number of insured in the comprehensive health insurance pool has declined as a result of another state-sponsored health plan to a point that continuation of the comprehensive health insurance pool is no longer feasible, the commissioner of finance and administration and the board of directors shall develop and implement a plan for the orderly termination of the Tennessee comprehensive health insurance pool.

SECTION 2. For purposes of promulgating rules and regulations, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes, this act shall take effect July 1, 2003, the public welfare requiring it.